Authorization of Release of Information

Prepared by ND Child Care Resource & Referral Health Consultant Team

Name of child: ____ **Date of Birth:** ____________

Address: ____

City: ___________________________________ **State:** _________ **Zip Code:** ______________

I, ____ hereby give permission for
(name of legal guardian)

____
(professional / facility)

to release ____
(screenings, tests, diagnoses and treatment, or recommendations)

for the child named above to ____
(child care program)

This information will be used solely to plan and coordinate the care of the child named above. This information will be kept confidential and only shared with:

____
(staff titles / names)

Signatures:

____ ________________________
(Signature of Parent/Guardian) (Date of signature)

____ ________________________
(Signature of Witness) (Date of signature)

Contact for additional information:

Name of contact: ____

Phone: ___________________________________ **Email:** ______________________________

Address: ____

City: ___________________________________ **State:** _________ **Zip Code:** ______________

Sources:
American Academy of Pediatrics, PA Chapter, (2002) Model Child Care Health Policies, 4th)

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